TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ahmed Khalifa, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-3567-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 8, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CERTIFYING EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual has no record of receiving the Report of Medical Evaluation. No has the requestor provided a copy with his DWC60 packet.

Absent the signed Report of Medical Evaluation, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2016	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.1 sets out the requirements for examinations to determine maximum medical improvement and impairment rating.
3. 28 Texas Administrative Code §133.210 sets out the requirements for medical records.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Are Texas Mutual Insurance Company's reasons for denial or reduction of payment supported?

Findings

Ahmed Khalifa, M.D. is seeking reimbursement of $650.00 for an examination to determine maximum medical improvement (MMI) and impairment rating (IR). Texas Mutual denied the disputed services with claims adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS."

28 Texas Administrative Code §133.210(b) states, "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents."

28 Texas Administrative Code §134.250(1) makes reimbursement contingent upon "the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets."

28 Texas Administrative Code §130.1(d)(1) states, "Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report."

Submitted documentation fails to support that a Report of Medical Evaluation was completed or submitted to the insurance carrier. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 6, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.